Montgomery County 2006 Group Insurance Election Form - Active Employees

PLEASE DO NOT
FOLD OR STAPLE
THIS FORM

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the response completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ✓ ✗ ◒ ◔

STATUS

○ Active

○ Other

Your Social Security Number

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

Name:
Address:

OHR ID No.

Part A YOUR CURRENT BENEFITS

Except for the Flexible Spending Accounts (FSA) which you must elect each year, this will be your default coverage for **2006**.

	MEDICAL	PRESCRIPTION (Rx)	DENTAL	VISION
Plan				
Coverage Level				
Optional Life				
Dependent Life				
* Health Care FSA 2005				
* Dependent Care FSA 2005				
Your Cost Share				
Your Group Insurance Plan				

* Note: To participate in the FSA's for 2006, you must complete the FSA Section in **Part H**.

YOUR 2006 BENEFITS PLAN ELECTIONS:

Basic Life Insurance and Long Term Disability Coverage, if eligible, are automatic mandatory benefits. For your Medical, Rx, Dental, and Vision elections, your coverage level will be determined by the number of dependents you enroll under the **"2006 Dependent Coverage Elections"** section in **Part I.**

IF YOU WANT TO MAINTAIN YOUR CURRENT BENEFITS AND ARE MAKING NO CHANGES TO BENEFIT PLANS OR DEPENDENT COVERAGE ELECTIONS FOR 2006, AND YOU DO NOT WISH TO PARTICIPATE IN THE FSA's FOR 2006, THEN YOU DO NOT HAVE TO RETURN THIS FORM.

Part B MEDICAL (Choose one)

- ○ Maintain Current Medical
- ○ No Medical Plan
- ○ Kaiser HMO (Includes Kaiser Rx)
- ○ Optimum Choice HMO (Medical Only)
- ○ Carefirst POS High Option (Medical only)
- ○ Carefirst POS Standard Option (Medical Only)

For eligible participants living outside the POS service:

- ○ Carefirst POS High Option - Out of Area (Medical Only)
- ○ Carefirst POS Standard Option - Out of Area (Medical Only)

Part C PRESCRIPTION (Rx) (Choose one)

- ○ Maintain Current Prescription Coverage
- ○ No Caremark Prescription Coverage
- ○ Caremark High Option $4/$8
- ○ Caremark Standard Option $10/$20/$35

Part D DENTAL PLAN (Choose one)

- ○ Maintain Current Dental
- ○ No Dental (Two year waiting period to re-enroll)
- ○ Dental PPO (Traditional Dental Plan)
- ○ Dental DHMO

Part E VISION PLAN (Choose one)

- ○ Vision Plan
- ○ No Vision Coverage (Two year waiting period to re-enroll)

DO NOT MARK IN THIS AREA

Part F OPTIONAL LIFE (Choose one)

- ◯ Maintain Current Coverage
- ◯ No Optional Life Coverage
- ◯ One times basic annual earnings
- ◯ Two times basic annual earnings
- ◯ Three times basic annual earnings

(If you are increasing Optional Life coverage, you must complete an Evidence of Insurability Form.)

Part G DEPENDENT LIFE (Choose one)

- ◯ Maintain Current Coverage
- ◯ No Dependent Life Coverage
- ◯ $2,000/$1,000/$100
- ◯ $4,000/$2,000/$100
- ◯ $10,000/$5,000/$100

Part H 2006 FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care FSA

Maximum annual amount for Health Care is **$2,500** for reimbursement of eligible out of pocket health care expenses for you or any person who qualifies as your dependent under the applicable provisions of the Internal Revenue Code.

HEALTH CARE

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

- **MUST BE COMPLETED TO PARTICIPATE FOR 2006**
- **WRITE IN ANNUAL DOLLAR AMOUNT**
- **MUST BE IN WHOLE NUMBERS**

DEPENDENT CARE

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

Dependent Care FSA

Maximum annual amount for Dependent Care is **$5,000** for reimbursement of eligible dependent care expenses, such as expenses for licensed day care centers.

Part I 2006 DEPENDENT COVERAGE ELECTIONS - DO NOT ADD OR DELETE DEPENDENTS ON THIS FORM

For each dependent listed below, choose the plans under which you want them to be covered. The number of dependents you cover under each plan will determine your coverage level, i.e, Self, Self +1, Family, and your cost for that plan. To enroll a dependent in a plan, you must have elected the coverage for yourself above. **If you wish to add an eligible dependent or delete an ineligible dependent, you must complete a dependent Addition / Deletion form and submit it to OHR along with the required documentation and this election form.**

	MEDICAL	PRESCRIPTION (Rx)	DENTAL	VISION
	Current - 2006	Current - 2006	Current - 2006	Current - 2006
1-	Y N	Y N	Y N	Y N
2-	Y N	Y N	Y N	Y N
3-	Y N	Y N	Y N	Y N
4-	Y N	Y N	Y N	Y N
5-	Y N	Y N	Y N	Y N
6-	Y N	Y N	Y N	Y N
7-	Y N	Y N	Y N	Y N
8-	Y N	Y N	Y N	Y N
9-	Y N	Y N	Y N	Y N
10-	Y N	Y N	Y N	Y N

Do not add or delete dependents on this form.

Part J SIGNATURE (Must be signed for elections to become effective)

I have read the materials for the County's group insurance program, as well as the information available on the individual benefit plans. This election form indicates my benefit elections and dependent coverage for calendar year 2006 and authorizes the County to make the necessary deductions to my pay based on these elections. If I have elected no coverage for medical, prescription, dental, and vision, I understand that it is important that I have such coverage elsewhere that is adequate to meet my needs and the needs of my dependents. In order to protect the tax exempt status of the group insurance program, I understand that these elections are in effect for the entire 2006 calendar year and can only be changed during the year if I have a Change in Status, as allowed under Section 125 of the Internal Revenue Code and described in the Summary Plan Description for the group insurance program. I also understand that the County has a right to adjust my benefit elections to comply with the requirements of the Internal Revenue Code. I authorize the release of information contained on this election form to entities such as benefit carriers, to the extent necessary to properly administer the benefits I have elected. I understand that electing benefits to which I, my dependents, or any other person are not entitled is considered fraud. In all cases, I am responsible for my benefit elections and those of other persons for whom I elect to be covered. I further understand that if I willfully misrepresent my eligibility or that of any other person on this election form, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled, I may be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from County service. I understand that the County expects to continue the group insurance program, but it is the County's position that there is no implied contract between employees and the County to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend the program, subject to the County's collective bargaining agreements, where applicable. Further, I understand that the program may also be amended by the County at any time, either prospectively or retroactively, to conform with the Internal Revenue Code.

Signature: _____ **Date:** _____

All forms must be signed and received in the Office of Human Resources, EOB 7th floor, 101 Monroe Street, Rockville, MD 20850, no later than **5:00 p.m., Monday, November 14, 2005.**